

## ***Recommendation 2***

### **Facility (ies)**

Victory Memorial Hospital (Kings County)

### **Recommended Action**

It is recommended that Victory Memorial Hospital close in an orderly fashion. Following this planned closure, it is further recommended that the site be converted under new sponsorship to a diagnostic and treatment center and/or as a facility offering a continuum of long term care services that would be compatible with the remaining Victory Nursing Home.

### **Facility Description(s)**

Victory Memorial Hospital is a 243-bed hospital in the southwest section of Brooklyn. It provides adult medical/surgical and obstetrics services. All of its certified beds are staffed. The hospital's 2004 certified bed occupancy rate was 62%, and the hospital had 23,808 emergency visits. Medicaid-covered and uninsured patients represented 34% of total inpatients in 2004. The hospital carries approximately \$32 million in long term debt, approximately \$26.9 million of which is DASNY debt, secured by the Federal Housing Administration's Hospital Mortgage Insurance Program. The hospital employed approximately 1,025 FTEs in 2003. The hospital has an adjacent, hospital-affiliated nursing home with 150 beds.

### **Assessment**

Victory Memorial declared chapter 11 bankruptcy in November 2006 following years of severe financial trouble. Victory continues to default on its obligations and has difficulty making payroll. The hospital is attempting to raise capital through a short-term loan, and sale of its property and its long-term home health care ("Lombardi") program. These short-term cash infusions, however, will not adequately ameliorate the facility's financial problems.

In 2005, in an effort to stabilize the institution, the Department of Health and Maimonides Medical Center structured a plan to stave off Victory's bankruptcy. As part of this bail-out plan, Victory received a \$2 million grant from the Department of Health, a \$1 million grant from the NYS Senate Speaker's fund, and a \$5 million loan from Maimonides Medical Center, which included a five-year partnership between the two medical centers as a condition of the loan.

Despite these efforts, Victory has entered chapter 11 bankruptcy proceedings. Its reported medical/surgical volume has steadily and sharply declined. Patients and physicians have defected to neighboring hospitals, primarily to Lutheran Medical Center. Cash flow is a major problem.

As part of its partnership agreement, Maimonides hired a consultant to develop a restructuring plan for Victory. The consultant found that even a smaller hospital would continue to lose money, even with unlikely increases of discharges. Maimonides then proposed evaluating whether Victory could be converted to either a diagnostic and treatment center (D&TC), providing needed primary care and outpatient obstetrics and mental health services to the community, or to a site for a continuum of long-term care services.

Victory can close as an inpatient facility without disruption to access to or availability of care. Were Victory to close, it initially appeared that approximately 25-35 patients may be difficult to accommodate at Victory's coverage partners, which include Maimonides, Lutheran, NY Methodist and Coney Island hospitals. A number of factors, however, mitigate this concern:

- Victory's 2004 average daily census was inflated by long lengths of stay relative to the borough average. If patients were treated instead at Victory's coverage partners, which have more appropriate lengths of stay, then many more patients could be covered by the remaining hospitals.
- Volume at Victory has declined further since 2004. Its average daily census has dropped to approximately 130. Surrounding institutions can definitely absorb Victory's current inpatient volume should Victory close.

- Physician referral patterns have already changed. Doctors have begun redirecting patients to other area hospitals.

Notably, the two recent Brooklyn hospital closures, St. Mary's and Brooklyn Hospital's Caledonian campus, were in the northern part of the borough. The primary service areas of those hospitals do not overlap with that of Victory.

The community does need access to comprehensive ambulatory care services. In 2004, Victory Memorial had approximately 85,000 outpatient visits. The community's access to outpatient care should be preserved when Victory closes. When Victory Memorial closes, efforts should also be made to ensure Victory Nursing Home's continuing survival.

The Commission recommends the immediate decertification of all inpatient beds at Victory. The entrance of the institution into bankruptcy proceedings is likely to place the interests of a creditors' committee in opposition to those of community health.

### ***Recommendation 3***

#### **Facility (ies)**

Peninsula Hospital Center (Queens County)

St. John's Episcopal Hospital South Shore (Queens County)

#### **Recommended Action**

It is recommended that Peninsula Hospital Center downsize by approximately 99 beds to approximately 173 beds and that St. John's Episcopal Hospital downsize by approximately 81 beds to approximately 251 beds. Contingent upon financing, it is recommended that Peninsula Hospital Center and St. John's Episcopal Hospital merge and rebuild a single facility with

approximately 400 inpatient beds, and provide comprehensive emergency, inpatient, psychiatric and ambulatory services.

### **Facility Description(s)**

Peninsula Hospital Center is a community teaching hospital located near the east end of the Rockaway Peninsula in Queens. The hospital is certified for 272 beds, of which 173 are available. In 2004, the hospital had approximately 5,707 discharges, 26,430 emergency department visits, and 33,929 visits at its primary care family health center. Medicaid-covered and uninsured patients represented 24% of discharges and 68% of emergency department visits. It offers medical/surgical, pediatric, and traumatic brain injury services. Peninsula has stroke center designation for southeast Queens, and is the acute care hospital affiliate of the Addabbo Family Health Center, one of two federally qualified health centers in Queens. Peninsula has improved the efficiency of its operations and reduced its length of stay. The hospital operates at a near break-even margin, and has little long-term debt (approximately \$3 million). Peninsula employed approximately 1,066 people in 2003, most of whom are local residents. Peninsula also runs an adjacent 200 bed hospital-based skilled nursing facility with a short-term rehabilitation unit, respiratory therapy, Alzheimer's disease and high-acuity services.

St. John's Episcopal Hospital is located at the far eastern end of the Rockaway Peninsula. It is certified for 332 beds, of which 251 are available. Its inpatient services include medical/surgical, maternity, psychiatry and detoxification services, and the hospital offers provides psychiatric outpatient services, a continuing day treatment program, home-based crisis intervention program, and outpatient services in adult homes. It is designated to receive emergency involuntary psychiatric admissions. In 2004, the hospital had approximately 10,708 discharges and 27,898 emergency department visits. Fifty-one percent of its inpatients and 48% of its emergency department visits were either Medicaid-covered or uninsured. The hospital showed an operating margin of 4% in 2004, and has long-term (DASNY) debt of approximately \$14 million. Like Peninsula, it is a major employer for the Rockaway community. St. John's Episcopal Hospital is part of Episcopal Health Services Inc., which also owns and operates two Rockaway-area nursing homes and the St. John's Medical Services PC.

### Assessment

The optimal solution to meet the health care needs of the Rockaways is the establishment and construction of one new hospital with an appropriate configuration of needed services and number of beds in a convenient location for the bulk of the population. Neither of the two hospitals runs at full capacity, yet neither can fully absorb the other's patient load. The mix of services between the two hospitals is relatively complementary, but they have unnecessary overlaps in medical/surgical capacity. Their medical staffs overlap. Both facilities are old and in need of extensive capital renovation. Neither has an adequate physical plant in the optimal location to serve the needs of this growing community. In an effort to avoid assuming more debt than it can comfortably carry, Peninsula Hospital has made steady but relatively small investments in its physical plant. St. John's has renovated part of its outmoded facility but more needs to be done.

This optimal health care delivery solution has major barriers to implementation, including considerable capital needs to cover construction costs, estimated at \$1 million/bed in the New York City region, and an apparent unwillingness by either of the providers to merge or consolidate.

This recommendation is shaped by the particularities of the Far Rockaways area, including:

- The Rockaways are located on an isolated barrier peninsula accessible by two bridges to Brooklyn and Queens, and by one road into Nassau County.
- 40% of the residents are African-American, compared to 25% in NYC as a whole.
- The NYC Department of Health and Mental Hygiene identified the Rockaways as an area with income and health disparities.
- It is difficult to attract and retain physicians to practice in the community.
- The middle-class population of the peninsula is growing, and there is an influx of younger families with children. Approximately 15-20,000 new residents are expected to

move into housing currently under construction. There is a migration of Orthodox and Russian Jewish and Hispanic immigrants from Central America into the community.

- The Peninsula is oversaturated with nursing home and adult home beds, which account for nearly 60% of the combined nursing and adult homes in Queens. There are 17 nursing homes and 12 adult homes on the Rockaway peninsula.

#### ***Recommendation 4***

##### **Facility (ies)**

Queens Hospital Center (Queens County)

##### **Recommended Action**

It is recommended that Queens Hospital Center add approximately 40 medical/surgical beds.

##### **Facility Description(s)**

Queens Hospital Center, a member of the NYC Health and Hospitals Corporation, is a 243-bed community hospital serving primarily the neighborhoods of Jamaica and southwest Queens. The hospital provides medical/surgical, maternity, and behavioral health services. It was recently renovated and downsized from 408 beds. Queens Hospital Center is an important safety-net provider to low-income communities with compromised access to health care services. Medicaid and uninsured patients represent 79% of inpatients and emergency department admissions. While Queens Hospital Center has 5% of the total certified beds in the borough, it has 19% of the alcohol detoxification beds, 26% of the drug detoxification beds, and 9% of the psychiatric beds. Queens Hospital Center employed approximately 1,911 FTEs in 2003. The hospital's strategic priorities include the development of a comprehensive cancer center, and the completion of a new ambulatory care pavilion.

**Assessment**

Queens Hospital Center developed its plans for the recently completed modernization prior to the St. Joseph's Hospital closure in 2004. Consequently, Queens Hospital Center's downsized bed capacity does not meet the needs of its community. On days of peak census, the hospital exceeds its certified capacity despite a relatively low 4.2 day length of stay. Its ED and inpatient units are overcrowded. An ambulatory pavilion construction project is underway, which could be modified to include a 40-bed inpatient expansion.

***Recommendation 5*****Facility (ies)**

Parkway Hospital (Queens County)

**Recommended Action**

It is recommended that Parkway Hospital close in an orderly fashion.

**Facility Description(s)**

Parkway is a 251-bed proprietary, for-profit community hospital located in Forest Hills, Queens. It operates 140 beds, and provides only adult medical/surgical care. It does not offer maternity, psychiatric, or pediatrics services. In 2004, it had approximately 9,365 discharges and 13,973 emergency department visits. Most of its patients have private coverage or Medicare. In 2004, the hospital's occupancy based on available beds was 66%, and it had an average daily census of 146. According to the hospital's administration, average daily census in 2006 further declined to 130. Its operating margin is approximately -5%.

It is one of only two for-profit hospitals in New York State. Parkway is the primary hospital for several physician group practices, many of which are owned by the hospital operators. These practices are located throughout Queens and Brooklyn. According to the hospital, in the first quarter of 2006, Parkway employed 570 full-time equivalent employees, down from 696 in the fourth quarter of 2004.

Parkway Hospital filed for Chapter 11 bankruptcy protection in June 2005. While the hospital hoped that it would emerge from bankruptcy in the third quarter of 2006, its losses for the first quarter of this year totaled \$4.7 million, which was \$2.5 million more than the hospital budgeted. Bankrupt Parkway Hospital lost \$810,542 in June 2006 alone, and patient revenue in June 2006 was \$5.5 million, which was under expected budget by \$825,000 due to of lower revenue from Medicaid and Medicare. In 2004, the hospital had approximately \$13 million in (non-DASNY) long-term debt. If the hospital emerges from bankruptcy, it must file a certificate of need application with DOH for change of ownership.

### **Assessment**

Using the Commission's framework criteria, Parkway Hospital is the only hospital in New York State to receive below-average scores on all six of the criteria: service to vulnerable populations, quality of care, utilization, viability, availability of services, and economic impact. The NYC RAC agreed that "using the need criteria ...and particularly considering this hospital's past problems with financial and administrative mismanagement, and more importantly, quality of care, Parkway is a prime candidate for closure."

Parkway's low occupancy rate and poor finances indicate that it is unneeded and cannot stand as a viable, stand-alone entity, surrounded by larger, more comprehensive facilities. Analysis using 2004 data, which is more favorable to Parkway than current data, to measure Parkway's capacity to close suggests that it might be difficult to accommodate all of Parkway's patients at other area hospitals. This concern, however, is mitigated by various factors. Parkway's extended lengths of stay inflated its 2004 average daily census. Reductions in lengths of stay would substantially reduce the number of occupied beds and patient days so that patients would be accommodated at

the hospital's coverage partners. Furthermore, Parkway's inpatient average daily census has declined since 2004, indicating that patients already have chosen to seek care in alternative facilities.

### ***Recommendation 6***

#### **Facility**

New York Westchester Square Medical Center (Bronx County)

#### **Recommended Action**

It is recommended that New York Westchester Square Medical Center close in an orderly fashion.

#### **Facility Description(s)**

Westchester Square Medical Center (WSMC) is located in the eastern Bronx. It is certified for 205 beds, of which 163 are staffed. The hospital provides only adult medical/surgical care and no specialty services. WSMC is a certified stroke center. The hospital claims it had 7,852 discharges and emergency room volume of 23,000 in 2005. WSMC operates at a near-breakeven operating margin. It is a sponsored member of the NY Presbyterian Health System (NYPHS). It employed approximately 575 FTEs in 2003.

#### **Assessment**

Westchester Square represents excess capacity in the system. It functions largely as a feeder to tertiary hospitals in NYPHS. An analysis measuring its capacity to close confirms that WSMC's patients could be absorbed by surrounding hospitals, including St. Barnabas Hospital, which

NYPHS also sponsors. Its principal neighboring coverage partners include Montefiore/Weiler Campus, Jacobi , Montefiore/Moses Campus, Our Lady of Mercy, and St. Barnabas hospitals.

Using the Commission's framework criteria, WSMC scored low on service to vulnerable populations, utilization, viability, and availability of services. Relative to regional institutions, its payor mix includes few Medicaid-covered and uninsured patients even though the hospital's service area in the south and northeast Bronx encompasses some federally designated medically underserved areas (MUAs). Twelve percent of the hospital's inpatients in 2004 were Medicaid-covered or uninsured. Moreover, it is underutilized and provides no specialty care. Its certified bed occupancy rate in 2004 was only 51%. WSMC provides only general medical/surgical services; it provides no maternity, psychiatric, or substance abuse care.

### ***Recommendation 7***

#### **Facility (ies)**

Cabrini Medical Center (New York County)

#### **Recommended Action**

It is recommended that Cabrini Medical Center close in an orderly fashion.

#### **Facility Description(s)**

Cabrini Medical Center (Cabrini) is an acute care hospital in Manhattan's Gramercy Park neighborhood. Cabrini's campus occupies an entire city block in downtown Manhattan, and contains five buildings. Two buildings are used for clinical care, and the remaining buildings are used primarily for hospital administration. It has a total of 474 licensed beds, of which, according to the hospital, 338 are in service. Approximately 25% of its certified and 73% of its available beds were occupied, and its medical/surgical volume has been in steady decline.

Cabrini offers inpatient medical/surgical, psychiatric, and rehabilitation services, and is a State-designated AIDS center. Its emergency department and outpatient clinics are well utilized. Cabrini had approximately 9,800 total discharges, 18,674 ED visits and 55,052 outpatient visits in 2004. It has a clinical affiliation with Mt. Sinai Hospital. The hospital employed approximately 1,357 FTEs in 2003.

The facility has been in financial difficulty for years, and missed payroll twice. While its recent financial condition has somewhat improved, it continues to struggle with fiscal problems. These improvements are largely attributable to efficiency gains, including a reduction in what had been a 14-day average length of stay. The 2004 operating margin was approximately -4%. The hospital reported that its losses in 2005 totaled approximately \$10 million. It has incurred approximately \$36 million debt to service, and \$44 million in unserviced debt to its sponsor, the Sisters of Cabrini. The hospital has no DASNY-insured debt, and it recently retired its debt to the NYS Housing Finance Authority with a private refinancing.

### Assessment

Cabrini Medical Center should close. According to the Commission's framework criteria, Cabrini scored poorly on utilization, quality of care, viability, and availability of services. Its score for the service to vulnerable populations criterion was average for the region.

In public presentations, Cabrini leadership acknowledged the strong arguments that support its closure:

- "We are located in 'Bed Pan Alley' with one of the largest concentrations of medical/surgical acute care hospitals in the country.
- The need for inpatient hospitalizations continues to shrink.
- We recognize Manhattan will unlikely ever again need the same number of medical/surgical beds. There is excess capacity and the continued arms race to fill beds among the existing competitors is not healthy.
- Like our neighbors, our financial picture has been troubled for over five years.

- We do not provide tertiary and quaternary services provided by our neighboring institutions.
- We sit on a very valuable piece of real estate that could easily be sold off for more condominiums.
- There is a growing consensus in many public arenas that the smaller institutions should either close or restructure.
- Virtually all providers are struggling and the responsible thing to do is to shrink or restructure over-capacity before we see even bigger and more catastrophic collapses and resulting declines in quality of care.”

The Commission’s capacity to close analysis confirms that Cabrini’s patients readily could be absorbed by its coverage partners, including Beth Israel Petrie Division, Bellevue, NYU Tisch, and Mount Sinai hospitals. The NYC RAC concluded “There is no continuing need for an inpatient medical/surgical capacity at this facility. While the administration and the board have been very aggressive in attempting to preserve Cabrini as a hospital, and have been creative in developing different configurations including reducing medical/ surgical beds, it appears to us that the surrounding hospitals can easily absorb inpatient admissions from this market area.”

Cabrini’s leadership impressed the Commission with its realistic self-assessment, candor, and their creative efforts to reconfigure the institution. The Commission is not persuaded, however, of the need to maintain Cabrini either in its current form or in the new form proposed by Cabrini leadership. Provisions must be made, however, to ensure continued access to certain services, especially psychiatry, outpatient, and emergency services. These services provided at Cabrini can and must be transferred to surrounding institutions without creating access problems for the community:

- **Psychiatry** – Neighboring Beth Israel Medical Center is prepared to assume all of Cabrini’s psychiatric beds, pending the State’s certificate of need approvals for such a transfer. Cabrini has 78 licensed inpatient psychiatric beds, including 28 recently approved geropsychiatric beds. Beth Israel has a comprehensive psychiatric program, including inpatient, outpatient, and community-based care. Under the proposed plan,

Beth Israel would convert the majority of its current inpatient detoxification beds to psychiatry, and transition approximately 75% of the inpatient detoxification program to outpatient clinics. This transition is consistent with trends in substance abuse care and with state policy objectives. Beth Israel's detoxification beds are located in a separate pavilion, together with the hospital's existing inpatient psych services.

The Commission also consulted with the leadership of NYU Medical Center. NYU-Tisch Hospital currently operates 22 inpatient psychiatric beds, and Bellevue Hospital operates 339 psychiatric beds at full capacity. NYU has space and resource constraints, but expressed a willingness to evaluate the expansion of inpatient psychiatric care should it be necessary in order to accommodate patients displaced by a Cabrini closure.

- **Outpatient services** – Beth Israel Medical Center's 300,000-square-foot Phillips Ambulatory Care Center is located within an easy walk to Cabrini, at the major public transportation hub of Union Square. Beth Israel easily can absorb an additional 50,000 outpatient visits at this site. In addition, NYU Medical Center plans to expand its primary care and general medical/surgical capacities at its nearby Hospital for Joint Diseases.
- **Emergency services** – Analysis evaluating Cabrini's capacity to close demonstrated that Cabrini's urgent/emergent patients can be absorbed at neighboring Bellevue, NYU Tisch, Beth Israel Petrie, and St. Vincent's Manhattan hospitals, all within appropriate travel times. In addition, the nearby NYU Tisch Hospital filed a CON application to double its emergency department's size and bed count.

Cabrini has relatively little debt for an institution of its size, and no DASNY debt. According to Cabrini, the real property on which the hospital sits is estimated to be worth approximately \$130 million, which easily will cover the hospital's debts and leave funds to support the overall health care mission of the sponsor.

### ***Recommendation 8***

#### **Facility (ies)**

Beth Israel Medical Center - Petrie Campus (New York County)

#### **Recommended Action**

It is recommended that Beth Israel–Petrie Campus convert approximately 80 detoxification beds to approximately 80 psychiatric beds, provided that the Commissioner of Mental Health and the Commissioner of Alcoholism and Substance Abuse Services approve such changes.

#### **Assessment**

This action will preserve community access to psychiatric beds currently located at Cabrini Medical Center.

### ***Recommendation 9***

#### **Facility (ies)**

North General Hospital (New York County)

#### **Recommended Action**

It is recommended that North General Hospital enter into a passive parent corporate relationship with Mount Sinai Medical Center.

**Facility Description(s)**

North General Hospital (NGH) is a community hospital in central Harlem in upper Manhattan. It has 200 certified beds, 152 of which were available in 2004. Sixty-four percent of its certified beds were occupied in 2004. In 2004, the facility had approximately 8,132 discharges and 31,709 emergency department visits. NGH provides inpatient medical surgical, psychiatry and alcohol detoxification services. In 2004, approximately 67% of its discharges were medical/surgical patients, 21% were substance abuse patients and 12% were psychiatry patients.

NGH is a safety net provider. Medicaid-covered and uninsured patients represented approximately 65% of inpatient cases, and 72% of inpatients live in federally-designated medically underserved areas (MUAs). About 60% of its patients are African-American, and about 40% are Hispanic. NGH's relatively high case mix index reflects the poor health status of its surrounding community. NGH employed approximately 921 FTEs in 2003.

Following years of clinical affiliations with a variety of partners, NGH entered into an affiliation in 2004 with The Mount Sinai Hospital. The affiliation includes collaborative clinical programs in anesthesiology, cardiology, dentistry, emergency medicine, gynecology, urology, ophthalmology, radiology, general surgery and vascular surgery.

**Assessment**

According to the Commission's analytic framework, NGH scored low on quality, viability, availability of services and quality of care. It scored high on service to vulnerable populations. While NGH serves medically underserved communities in Harlem, it is neither the only nor the largest provider of care to these communities. A capacity to close analysis demonstrated that NGH's patients could be served by surrounding hospitals, including Mount Sinai, Metropolitan, Harlem, St. Luke's Roosevelt - St. Luke's Division, NY Presbyterian - Columbia University, and Lenox Hill hospitals. NGH may see increasing competitive pressures when Harlem Hospital completes its renovation and modernization.

NGH suffers from a heavy debt load. Established in 1979, NGH was the last hospital built immediately prior to seriously disadvantageous changes in Medicare's capital reimbursement methodology. As a result, it was overbuilt, and the revenue cannot cover its tremendous debt load. In 2004, the hospital had a long-term debt load of approximately \$155 million, \$141 million with DASNY. Its debt is secured through a state service contract, so that the State is obligated to pay its debt should the hospital default on payments. Over the years, the hospital has consistently received loans and grants from the State in order to ensure its continued existence.

NGH's new leadership has made significant improvements. While it suffered from annual operating losses between 1996 and 2004, it enjoyed a positive margin in 2005, its first in ten years, and it is projecting a surplus for 2006. NGH claims that the improvements are not a result of one-shot transactions, but rather a result of their comprehensive turn-around plan and clinical affiliation with Mount Sinai. NGH claims that inpatient discharges increased by 30% between 2003 and 2005, emergency department visits increased by 15%, and that concomitantly, average length of stay dropped by 7%.

NGH's relationship with Mount Sinai has benefited NGH by allowing NGH to expand its clinical programs and attract new clinical leaders, including nine new chairs and chiefs and a new chief nursing officer. In 2004, NGH and Mount Sinai received approval to convert existing outpatient departments to diagnostic and treatment centers, which generated additional incremental revenue to support their ambulatory operations. Finally, NGH and Mount Sinai received joint approval for a jointly sponsored diagnostic catheterization laboratory at NGH.

NGH and Mount Sinai together have developed a plan for NGH to form a passive parent relationship with Mount Sinai. The two hospitals would continue to share administrative and information technology services, which will improve North General's bottom line. The two hospitals also proposed to reconfigure their clinical services; potentially relocating Mount Sinai's psychiatric to NGH. Finally, they launched a joint community-outreach and education venture to improve the health status of Harlem residents. Under the proposed passive parent relationship, tertiary referrals would presumably flow from NGH to Mount Sinai. This affiliation would

allow NGH to receive better creditor rates for loans, more competitive prices for goods and services, and improve NGH's leverage in rate negotiations with insurance companies.

The Commission supports NGH's restructuring plan. The recent turnaround spearheaded by NGH's CEO and board is impressive, particularly given its decades of struggle and a heavy debt burden. The proposed relationship with Mount Sinai provides the best possible avenue for the hospital to achieve stability and to advance its mission in Harlem.

### ***Recommendation 10***

#### **Facility (ies)**

St. Vincent's Midtown Hospital (New York County)

St. Vincent's Manhattan (New York County)

#### **Recommended Action**

It is recommended that St. Vincent's Midtown Hospital close in an orderly fashion. It is further recommended that approximately 12 psychiatric beds currently operated by St. Vincent's Midtown Hospital be added by St. Vincent Catholic Medical Center system (SVC MC) and operated by St. Vincent's Manhattan, provided that the Commissioner of Mental Health approves such additions. Should St. Vincent's Manhattan deem that to be impracticable, it is recommended that such 12 psychiatric beds instead be added elsewhere in New York County by another sponsor, provided that the Commissioner of Mental Health approves such additions. It is further recommended that ambulatory care services currently provided by St. Vincent's Midtown Hospital be maintained or developed in this neighborhood by SVC MC or another sponsor.

**Facility Description(s)**

St. Vincent's Midtown Hospital is a non-merged affiliate of the St. Vincent Catholic Medical Center; therefore, it is not subject to SVCMC's current bankruptcy proceedings. Located on the west side of midtown Manhattan, the hospital has 250 licensed beds, of which 149 are available. Its occupancy rate based on certified beds is 34%. The hospital's services include adult medical/surgical care, a small 12 bed psychiatry unit, and an inpatient detoxification program. According to information supplied by the hospital, it had just over 7,100 discharges and approximately 28,000 emergency department visits in 2005. The hospital employed approximately 670 FTEs in 2003.

**Assessment**

St. Vincent's Midtown Hospital should close. It is poorly utilized, and area residents are unlikely to receive care at St. Vincent's Midtown, preferring to receive care at its neighboring institutions. The hospital has less than a 10% share of its own primary service area. According to the hospital, more than 50% of patients served by St. Vincent's emergency department are not Manhattan residents, further evidence of low community dependence.

A quantitative capacity to close analysis showed that the average daily inpatient census of 85 patients could readily be absorbed by the hospital's coverage partners, including the two divisions of St. Luke's Roosevelt, Beth Israel Petrie Division, Mount Sinai, Bellevue, St. Vincent Manhattan, NY Presbyterian/Columbia, and Lenox Hill hospitals.

Patients seen in the St. Vincent's Midtown emergency department could also be absorbed elsewhere within reasonable travel times. According to the hospital, only about 10% of the 28,000 patients that arrive at the St. Vincent's Midtown emergency department are admitted to Midtown. Another 800 are transported downtown to St. Vincent's Manhattan on 12<sup>th</sup> Street. Furthermore, a major emergency department expansion project at the St. Luke's Roosevelt - Roosevelt Division, which is within ten blocks of St. Vincent's Midtown, will easily accommodate potential patients displaced from a St. Vincent's Midtown closure. The Roosevelt

emergency department is expanding from 16,500 to 27,000 square feet, from 27 to 51 treatment stations, and from a capacity of 54,000 to an estimated capacity of 100,000 visits. The renovation has the potential to include an urgent-care facility to treat the bulk of patients who do not require admission. This expansion will be able to absorb the St. Vincent's Midtown emergency department volume. Finally, St. Vincent's Midtown's physical plant is inefficient and is spread across two sides of a street.

St. Vincent Midtown had approximately 53,000 outpatient visits in 2004, excluding visits to its methadone programs. The Commission carefully evaluated whether alternate outpatient facilities could absorb St. Vincent's Midtown outpatient visits. St. Vincent Midtown and a federally qualified health center (FQHC) are currently negotiating for the FQHC to assume management of St. Vincent's ambulatory care operations. Furthermore, an additional FQHC is within blocks of the hospital and it too can absorb a significant portion of this volume.

The hospital lost \$1 million in 2005 and has very little cash on hand. While St. Vincent's Midtown nears a breakeven operating margin, the SVCMC leadership reported that the service mix currently provided at the site cannot sustain the hospital's viability and solvency. The medical/surgical inpatients generally are low-acuity, and the majority of its detoxification patients could and should be treated in an outpatient setting.

The hospital has approximately \$49.8 million in long-term debt, approximately \$41 million of which it owes to DASNY. Midtown Manhattan real estate values remain high, particularly in the up-and-coming Clinton neighborhood where the hospital is located, and a sale of the building would cover a complete repayment of its debt. According to system leadership, sale of the St. Vincent Midtown campus would generate approximately \$90 million.

SVCMC presented an alternate plan for the Midtown campus. SVCMC proposed to further integrate Midtown with the downtown campus, which itself requires major physical and programmatic reconfiguration, including complete overhaul of its hospital once they emerge from bankruptcy. SVCMC proposes to reconfigure services between its two Manhattan campuses, and to reconstruct the Midtown campus to accommodate fewer inpatient beds, an

ambulatory surgery facility focused on orthopedics, and an emergency department with an expanded urgent care facility. They proposed to reduce medical/surgical capacity from 137 to 56 beds, to transfer 33 psychiatric beds from the St. Vincent's Manhattan (downtown) site to the Midtown site, and to transfer a 20-bed acute rehabilitation unit from the downtown site to the Midtown site to support Midtown's proposed orthopedic program. They would discontinue detoxification services.

Rather than endorse SVCMC's restructuring plan, the Commission recommends that St. Vincent Midtown close. The midtown Manhattan community does not need a 56-bed medical/surgical facility. The surrounding community is not dependent on the hospital. Several comprehensive facilities that serve the same patients can readily absorb Midtown's inpatient and emergency department volume, and are within blocks of the current location. Additionally, the transfer of psychiatric beds to St. Vincent's Manhattan or another area sponsor will preserve community access to psychiatric beds. There is little demand within Manhattan for another orthopedic specialty hospital, which would have to compete with Hospital for Joint Diseases, the Hospital for Special Surgery, and the comprehensive Orthopedics programs at other academic medical centers. Finally, sponsors have been identified to ensure continuation of outpatient services.

The State should not sustain an unneeded hospital campus in order to shore up another hospital in a system. Sustaining an unneeded hospital is not supportable within the Commission's charge, which specifically targets opportunities to right-size the delivery system in order to best meet community need.

### ***Recommendation 11***

#### **Facility (ies)**

New York Downtown Hospital (New York County)

**Recommended Action**

It is recommended that New York Downtown Hospital decertify approximately 70 medical surgical and 4 pediatric beds, reducing its licensed capacity from 254 to 180. It is further recommended that New York Downtown Hospital discontinue its inpatient pediatric services and that these services be added to other facilities. It is further recommended that New York Downtown Hospital reorganize its outpatient clinics under new sponsorship.

**Facility Description(s)**

New York Downtown Hospital, located in the heart of the financial district, is the only community hospital in lower Manhattan. The hospital has 254 certified beds, of which approximately 150 are in service. In 2004, it had a 34% occupancy rate of its certified beds, and 80% of its staffed beds. In 2004, there were approximately 11,306 discharges, 30,409 emergency department visits. According to NY Downtown leadership, the hospital had approximately 100,000 outpatient visits in 2005. The hospital's inpatient services include adult and pediatric medical/surgical care and obstetrics. More than 40% of inpatient discharges are obstetrics cases. The hospital employed approximately 1,091 FTEs in 2003.

Approximately half the hospital's admissions originate as emergency department visits. As the closest hospital to Manhattan's growing Chinatown, NY Downtown has a 48% market share of this community and approximately 49% of its patients are Asian. Vulnerable populations constitute a substantial portion of the hospital's patients. Forty-seven percent of inpatients are Medicaid-covered or uninsured, and 56% of patients come from medically underserved areas. Patient volume is likely to increase, as the commercial and residential population of this area is growing and multiple construction programs are underway and planned.

**Assessment**

NY Downtown Hospital's situation is complex and presents many financial and health delivery challenges. The hospital has a history of operating losses, although the magnitude of these has

been steadily declining since 2003. In 2003, it lost approximately \$18 million, in 2004, \$15 million, and in 2005, \$13 million. NY Downtown projects an operating loss of \$9.7 million in 2006 and \$7.4 million in 2007. The progressive decline in operating losses has been attributed to management's expense reduction initiatives and the renegotiation of managed care contracts. In 2004, the hospital had long-term debt of approximately \$74.6 million, approximately \$51 million of which was with DASNY.

Two events severely impacted the hospital's financial standing. First, as the closest hospital to the World Trade Center site, NY Downtown was heavily impacted by September 11<sup>th</sup> due to the inaccessibility of the hospital due to the area's security measures. Its admissions did not begin to rebound until 2003. Second, in 2004, NYU Medical Center severed its sponsorship arrangement with NY Downtown, and once again, NY Downtown's volume of business declined. Today, NY Downtown is affiliated with the New York Presbyterian Health Care system. The volume of admissions is approaching that of 2000, prior to the two events described above.

NY Downtown has a newly renovated \$25 million emergency facility designed to serve the urgent and emergency needs of the growing Downtown community. The emergency department is 28,000 square feet, and includes state-of-the-art individual asthma treatment stations, a chest pain emergency unit, a women's health suite, an expanded PromptCare service to expedite care for non-acute patients, and the largest decontamination facility in the City.

The hospital recently sold an adjacent parking lot for \$75 million in cash to commercial developers. The hospital used approximately \$55 million of this to pay vendors, invest in a major new IT system, settle claims with NYU arising from the dissolution of the previous sponsorship arrangement, and provide additional cash collateral to DASNY; approximately \$20 million has not yet been spent.

Nearly 50% of NY Downtown's patients were Medicaid-covered or uninsured in 2004. The majority of the hospital's inpatients are maternity and medical cases, which are neither highly reimbursed nor particularly profitable, and its high-volume emergency department and clinics serve a large uninsured population. Analysis measuring the impact of NY Downtown's closure

demonstrated that its patients could be absorbed by its coverage partners, including Beth Israel's Petrie Division, Bellevue, NYU Tisch, St. Vincent's Manhattan, Maimonides Medical Center, Lutheran Medical Center and NY-Presbyterian Weill Cornell Division hospitals. Notably, while NY Downtown has developed a strong relationship with the Asian community, St. Vincent's Manhattan and Beth Israel, both of which are located in downtown Manhattan, have also successfully reached out to the Asian population.

Quality of care at NY Downtown is improving. In 2004, it was named as one of 100 most improved hospitals by Solucient, and, in 2006, it won first prize in New York State's patient safety award program. The Leapfrog Group has recognized the hospital for its computerized drug prescribing systems. The medical staff has been strengthened with the recruitment of new physician leadership: a chief medical officer, chiefs of anesthesiology, obstetrics and gynecology, and surgery, and a director of geriatrics.

The Commission carefully reviewed NY Downtown's strategic plan, developed in cooperation with New York Presbyterian Health Care System (NYPHCS), of which NY Downtown is an affiliate. The plan includes achievable initiatives that have the potential to bring the hospital to a break-even position in 2008, including elimination of inpatient pediatrics and consolidation of this service with NYPHCS, and restructure and divestiture of its three outpatient clinics, and without an addition of unneeded tertiary services.

The proposed amalgamation of NY Downtown's pediatric care with that of NYPHCS will improve both NY Downtown's bottom line and its quality of pediatric care. Second, the proposed financial restructure of the hospital's three outpatient clinics will save NY Downtown approximately \$2 million a year. The hospital has approached various community clinics, including the Chinatown Health Clinic, and is exploring several options to restructure its outpatient financing while maintaining access to services. NY Downtown also plans to collaboratively develop with NYPHCS an occupational health and preventive services program in a yet-to-be constructed 25,000 square-foot space adjacent to the hospital.

The Commission rejected the possible closure of NY Downtown Hospital. While lower Manhattan may not require a full-service acute care hospital, the community served by NY Downtown does need access to emergency and ambulatory services. NY Downtown fulfills these needs. The services at NY Downtown, the level of investment in its new emergency department, its dedication to the medically underserved populations of Chinatown and lower Manhattan, the strength of the hospital's strategic recovery plan, and its substantial debt argue for the maintenance of this facility. Financing its closure and the necessary reestablishment of many of its services does not make economic sense.

NY Downtown's challenging financial situation exemplifies the need for systemic reimbursement reform. The conversion of NY Downtown to an emergent/urgent care center with a strong ambulatory care presence might best align community resources and needs. Given the current reimbursement methodology, however, such a conversion would leave the hospital's finances dangerously vulnerable. In order to provide emergency and ambulatory care, a hospital must cross-subsidize these services with acute and/or tertiary services for which there is less demonstrable need. Absent changes in reimbursement, it is not feasible to convert NY Downtown to a more appropriately configured and financially viable facility.

## ***Recommendation 12***

### **Facility (ies)**

Manhattan Eye Ear and Throat Hospital (New York County)

### **Recommended Action**

It is recommended that Manhattan Eye Ear and Throat Hospital downsize all 150 beds.

**Facility Description(s)**

Manhattan Eye Ear and Throat Hospital (MEETH) provides treatment for diseases of the eye, ear and throat, and also offers plastic and reconstructive surgery. It is one of two such specialty hospitals in New York City. The hospital is licensed for 150 beds, of which 30 are in service. According to the provider, the average daily census is 3 inpatients with a 10% occupancy rate based on available beds. The hospital's primary service is ambulatory surgery, and it performs approximately 50 outpatient surgeries per day. MEETH provides outpatient clinics in ophthalmology, otolaryngology and plastic surgery. Eighty-five percent of these outpatient visits are for elective plastic surgery. The hospital has lost money annually since 1998, and projects a \$7.7 million operating loss in 2006. MEETH employed approximately 241 FTEs in 2003.

**Assessment**

MEETH's former board of directors sought to close the hospital in 1999. The MEETH medical staff opposed the closure, and the Office of the New York Attorney General required MEETH to find a new sponsor for the institution. In 2000, Lenox Hill Hospital became MEETH's sponsor, holding typical reserved powers, but each institution has retained separate licensure. Lenox Hill has invested approximately \$40 million in MEETH.

Lenox Hill seeks to conclude a full asset merger with MEETH and reconfigure MEETH. Prior to implementing this change, the Office of the New York Attorney General required Lenox Hill to issue a request for proposals from all possibly interested institutions to sponsor or take over MEETH. While many health systems expressed initial interest, no proposals besides that from Lenox Hill were ultimately submitted. Lenox Hill's plan for MEETH includes the preservation of its outpatient services, the closure of all of its inpatient beds, the sale of part of MEETH's real estate holdings, and the possible lease of space to Calvary Hospital to establish end-of-life cancer services in Manhattan. The Commission supports this direction.

## NEW YORK CITY REGION

### LONG-TERM CARE RECOMMENDATIONS

#### *Recommendation 1*

##### Facility (ies)

Split Rock Rehabilitation and Health Care Center (Bronx)

##### Recommended Action

It is recommended that Split Rock Rehabilitation and Health Care Center close, downsize or convert, contingent on the determination of the Commissioner of Health, after a comprehensive review of the facility in light of the Commission's analytic framework, that such closure, downsizing or conversion would be consistent with the mandate and other recommendations of the Commission.

##### Facility Description(s)

Split Rock Rehabilitation and Health Care Center is a 240-bed proprietary residential health care facility that provides baseline services, and has ventilator-dependent beds and an adult day health care program. It had an occupancy rate of less than 93% in 2004. In addition, there have been quality concerns at the facility.

**Assessment**

This facility was identified as a facility of interest based on the Commission's criteria. The Commission repeatedly contacted the administrator of this facility, but has received no response to date. Closure, downsizing or conversion may be warranted. The Commissioner's review should be completed by June 30, 2007, and any closure, downsizing or conversion should be completed by June 30, 2008.

**NYC Regional Assessment**

After careful review, the Commission concludes that the NYC region does not have a significant excess of nursing home beds. In addition, the prime opportunities for right-sizing in NYC are being completed on a voluntary basis through the State's rightsizing demonstration program.

When evaluating the long-term care delivery situation in New York City, the following facts were considered:

- While the NYC region has roughly one third (38%) of all nursing home beds in the State, it also has around half of the State's population.
- Looking at beds per seniors 1,000 seniors, NYC has 48 beds/1000 while NYS as a whole has 52 beds/1000.
- Four out of five counties (boroughs) that comprise the NYC region, except the Bronx, have bed deficits based on the State's bed need methodology.
- Richmond County (Staten Island) has a calculated need for 295 additional beds and its existing beds are over 96% occupied. Additionally, Staten Island is among the fastest growing counties in the State, with a projected population increase of 42% over the next 30 years.
- Queens County has a calculated need for over 1,700 beds. Queen County is also projected to grow rapidly, by over 30% in the next 30 years. Within Queens, there may be some

excess beds concentrated in the Far Rockaways section. The Commission assessed selected facilities in the Rockaways that are implementing needed turn-around plans.

- New York County (Manhattan) has a documented need for 733 additional beds and an occupancy rate of over 97%. Manhattan nursing homes do have a relatively high proportion of low acuity residents but the cost of real estate in Manhattan generally makes the creation of ALPs unaffordable.
- Kings County (Brooklyn) has a documented need for 938 additional beds. Two Brooklyn facilities are under investigation by the State Attorney General and their future is uncertain; their closure could further exacerbate the shortage.
- On paper, Bronx County has a documented excess of over 2,000 beds and provides over 86 beds per 1,000 seniors. However, Bronx beds are 97% occupied, which is one of the highest average occupancy rates in the entire State. There were no Bronx-based facilities that performed especially poorly across the Commission's review criteria.

Furthermore, activities within the NYC market independent of the Commission are rightsizing the region's nursing home bed supply. Specifically:

- Florence Nightingale Health Center in Manhattan recently closed in 2005. Its closure removed 561 beds from the region's supply.
- Menorah Home and Hospital for the Aged and Infirm (Bushwick) in Brooklyn recently closed in 2005. Its closure removed 206 beds from the region's supply.
- A nursing home in Brooklyn is planning to close within months. Its closure will remove 45 beds from the region's supply.
- In Round 1 of the State's Nursing Home Rightsizing Demonstration, NYC-based facilities decertified 571 beds, or 80% of the total beds decertified statewide.
  - Terence Cardinal Cooke Health Center in Manhattan decertified 156 beds
  - Beth Abraham Health Services in the Bronx decertified 72 beds
  - Cobble Hill Health Center in Brooklyn decertified 156 beds
  - Menorah Nursing Home in Brooklyn decertified 21 beds
  - Metropolitan Jewish Geriatric in Brooklyn decertified 156 beds
  - Rutland Nursing Home in Brooklyn decertified 10 beds

- Nursing homes in the NYC region have applied in Round 2 of the State's Nursing Home Rightsizing Demonstration. If approved, these applications would decertify additional beds from the region's supply and create additional LTHHCP and ALP slots.

## NORTHERN REGION

### ACUTE CARE RECOMMENDATIONS

#### *Recommendation 1*

##### **Facility (ies)**

Bellevue Woman's Hospital (Schenectady County)

##### **Recommended Action**

It is recommended that Bellevue Woman's Hospital close in an orderly fashion. It is further recommended that Bellevue Woman's Hospital's maternity, neonatal, eating disorders, and mobile outpatient education and screening services be added to another hospital in Schenectady County.

##### **Facility Description(s)**

Bellevue Woman's Hospital is one of two remaining not-for-profit women's specialty hospitals in the nation, and the only one in the State. It has 55 certified beds, 40 of which were staffed in 2004. Its average daily census was 22 patients in 2004. Its chief service line is low-risk obstetrics. It had approximately 2,200 deliveries in 2004. It also had approximately 2,000 ambulatory surgeries in 2004, and houses breast and pelvic care health centers. Bellevue has partnered with a local mental health provider and the local medical college to train specialists in eating disorder treatment. It does not offer high-risk maternity care, medical surgical care, or emergency services. Eighteen percent of Bellevue's patients in 2004 were Medicaid-covered.

Assessment

The hospital's financial situation is dire and its future viability is in serious jeopardy. It has a substantial debt load and its business model is dependent on the provision of poorly-reimbursed obstetrical services. As of 2004, the hospital's (non-DASNY) long-term debt was approximately \$15.5 million. Bellevue has tried to address its financial problems by diversifying the hospital's service base and securing philanthropic support. These measures, however, have proven to be insufficient. Financial statements for 2004 and 2005 indicate a negative net worth, significant debt, and losses from operations. The hospital's net deficits at the end of 2004 and 2005 were respectively \$1.192 million and \$1.320 million, and its total deficit as of the end of 2005 was \$17.690 million. Additionally, Bellevue is unaffiliated with any other hospitals or systems that could provide substantial financial or management assistance to improve the current financial situation.

A capacity to close analysis confirms that Bellevue's patients readily could be absorbed by its coverage partners, including St. Clare's, St. Peter's Albany and Albany Medical Center hospitals. Provided that its distinctive level II neonatal intensive care and an eating disorder program services are transferred to one of the other area hospitals, Bellevue's closure will not affect availability of care. Furthermore, most complicated obstetric and neonatal cases are already diverted to the larger area hospitals, so closing Bellevue will not affect provision of these more high-tech services.

Consolidation of services offered by Bellevue with another area hospital will have quality of care and financial benefits. Consolidating all of Schenectady institutions' deliveries (approximately 3,000 annual births in 2004) into a single area hospital would allow investment in a more comprehensive neonatal intensive care unit than is currently offered by Bellevue. Its closure will also improve the viability of the remaining hospitals in Schenectady by allowing them to capture Bellevue's patient base, a high percentage of which is privately insured.

Bellevue employed approximately 275 FTEs in 2003, which was less than 0.5% of the workforce in Schenectady County. If Bellevue closes, its employees will be easily employed by other

institutions because the elimination of services at Bellevue will be accompanied by a transfer of its services elsewhere in the area.

## ***Recommendation 2***

### **Facility (ies)**

St. Clare's Hospital (Schenectady County)

Ellis Hospital (Schenectady County)

### **Recommended Action**

It is recommended that St. Clare's Hospital and Ellis Hospital be joined under a single unified governance structure with full authority to restructure the hospitals, rationalize bed and clinical capacity, minimize duplication of services and capital investment, and develop an integrated health care delivery system. It is further recommended that the resulting entity downsize from 568 beds to between 300 and 400 beds, representing a downsizing of between 168 and 268 beds. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff. If St. Clare's and Ellis Hospitals fail to execute such an agreement by December 31, 2007, it is recommended that the Commissioner of Health close one of the facilities and expand the other to accommodate the patient volume of the closed facility.

### **Facility Description(s)**

Ellis Hospital is a community hospital in Schenectady, located in close proximity to St. Clare's Hospital. Ellis Hospital has 368 certified beds, of which 272 were staffed in 2004. Its average

daily census was approximately 256. Seventy-one percent of its available beds were occupied in 2004. It provides medical/surgical, emergency, inpatient psychiatric, and outpatient services. Its services include a stroke program, cardiac catheterization, angioplasty, and cardiac surgery. It eliminated its obstetrical services in 2000. Ellis has approximately 33,000 emergency room and 34,000 outpatient visits in 2004. Eight percent of its patients were either covered by Medicaid or uninsured in 2004, and its uncompensated care cost is estimated to have cost the hospital \$3.4 million in 2004. Ellis employed approximately 1,550 FTEs in 2003, which was just over 2% of the workforce in Schenectady County. There are 82 skilled nursing facility (SNF) beds located within the hospital plant.

After several years of negative balances, Ellis's financial situation improved, and it now enjoys a positive operating margin. In 2004, Ellis spun off a primary care clinic and re-established it as a federally qualified health center (FQHC) to take advantage of FQHC's higher reimbursement rates. Ellis also reduced the number of its full-time equivalent employees. Ellis carried a substantial debt load of approximately \$37.9 million in 2004, \$33.2 million of which is with DASNY.

St. Clare's Hospital is a Catholic community hospital with 200 certified beds, of which, according to the hospital, 118 are staffed. Its average daily census was 84 in 2004. It offers medical/surgical, emergency, and obstetric services, as well as a 6-bed geriatric unit and an outpatient sleep disorders unit. St. Clare's has approximately 38,000 emergency department and 51,000 outpatient visits per year. St. Clare's Hospital employed approximately 921 FTEs in 2003, which was just over 1% of the workforce in Schenectady County.

St. Clare's is the main safety net provider in Schenectady. Twenty percent of its inpatients are either covered by Medicaid or uninsured. St. Clare's uncompensated care cost in 2004 is estimated to have cost the hospital \$7.6 million.

The service and payor mix at St. Clare's has placed the hospital in financial jeopardy. St. Clare's operating margin in 2004 was -5%. In 2004, it carried only \$4.5 million of (non-DASNY) debt; however, its pension plan is underfunded by \$27 million. The hospital has little cash. It has

limited ability to make the kinds of future investments that are required for it to remain competitive and efficient.

### Assessment

Both Ellis and St. Clare's are underutilized. With adequate preservation of the core services provided by St. Clare's to underserved populations, a consolidation of the two hospitals will reduce costly duplication of services and create efficiencies. These savings could be re-invested in other needed services such as primary and preventive care. The efficiencies to be derived by consolidating the expertise of St. Clare's in the delivery of high-volume, low-reimbursement services with Ellis' expertise in the delivery of more specialized, high-reimbursement services will allow greater cross-subsidization, thereby ensuring the ongoing stability of essential services.

The care provided by both Ellis and St. Clare's hospitals is generally adequate. Ellis's stroke and heart attack care is excellent. The consolidation of Ellis and St. Clare's likely will improve the quality of heart attack and heart failure care at both facilities. Similarly, a stronger relationship between the geriatric acute care unit at St. Clare's and Ellis' residential health care facility will improve the area's quality of elder care.

Absent a consolidation of Ellis and St. Clare's, competition between the two major hospitals in Schenectady will continue to erode and destabilize both hospitals. Both hospitals will face mounting financial difficulties, which will likely culminate in the bankruptcy and/or closure of one or the other. A failure to unite the hospitals will necessitate further, otherwise unnecessary infusions of capital, most likely from the State, as private lenders are unlikely to be willing to invest in such an unstable market.

There should be only one hospital or health system providing inpatient care in Schenectady county. The consolidation of Ellis and St. Clare's will improve the viability of both hospitals, support improvements in quality of care, minimize the need for State subsidy, eliminate the duplication of services between those entities and allow services to be rationalized between the

two campuses. This consolidation will reduce costs by eliminating the excess capacity at both campuses, and propel the reuse and conversion of the facilities and capital resources to more appropriate uses.

## NORTHERN REGION

### LONG-TERM CARE RECOMMENDATIONS

#### *Recommendation 1*

##### Facility (ies)

Ann Lee Infirmary and Albany County Home (Albany)

##### Recommended Action

It is recommended that Ann Lee Infirmary and Albany County Home merge, downsize by at least 345 RHCF beds, rebuild a unified facility, and simultaneously add or contractually provide financial support for non-institutional services.

##### Facility Description(s)

Both Ann Lee and Albany County Home are residential health care facilities owned and operated by Albany county. Ann Lee has 175 certified beds, and Albany County Home has 420 certified beds. Both facilities have low occupancy. According to the County, Albany County Home currently occupies only 60% of its beds in 2003, and Ann Lee occupies 91% of its beds. The homes have been operating with substantial financial losses for several years. The County reports having provided more than \$5 million in 2005 to subsidize these facilities.

The facilities raise quality of care concerns. According to recent State surveys, Albany County Home had 14 deficiencies and 1 citation for actual harm, and Ann Lee had 5 deficiencies with 1 citation for actual harm. Ann Lee's case mix index from 2003 (0.87) was the lowest in the State.

This low CMI has a tremendous impact on the facility's revenue. If Ann Lee merges with Albany County Home, Ann Lee's CMI and revenues will increase.

### **Assessment**

The County of Albany has a low nursing home occupancy rate (93% in 2004). In addition, nursing homes in the county of Albany lose residents to those facilities in Saratoga County.

Merging Ann Lee and Albany County Home will ameliorate problems associated with the low occupancy of the two facilities. Both facilities are old and out-of-date, and are unsuitable for modern skilled nursing care. Amalgamating the two homes will enable the newly constructed facility to use capital funds more resourcefully. A new facility with a regionally appropriate bed count will improve quality of care and the financial standing of both the newly merged facility and the County, which will no longer have to subsidize two inefficient facilities.

### ***Recommendation 2***

#### **Facility (ies)**

The Avenue and The Dutch Manor (Schenectady County)

#### **Recommended Action**

It is recommended that The Avenue and The Dutch Manor merge and downsize both facilities by approximately 48 RHCF beds to approximately 200 RHCF beds in a rebuilt Avenue facility. It is further recommended that the merged entity add a 50-bed ALP, a 25-slot ADHCP and possibly other non-institutional services in a renovated Dutch Manor facility.

### Facility Description(s)

The Avenue and The Dutch Manor are owned and operated by an eight-facility proprietary group. The group runs five facilities in the Northern region. The Avenue is a 224-bed residential health care facility and the Dutch Manor is an 86-bed facility. Both provide baseline services and sub-acute care.

These facilities are located a short distance from each other. Both have weak occupancy. In 2003, the Avenue occupied approximately 48% of its beds, and the Dutch Manor occupied approximately 78% of its beds.

The Avenue has suffered from significant operating losses for the last several years. Approximately 20% of its residents were low-acuity in 2003. Its quality has varied over the years. In its latest survey, the Department of Health cited three deficiencies, including one for actual harm. It is housed in a building from the 1950s, and past scandals have hurt its reputation.

The Dutch Manor, on the other hand, attracts a good private pay market and is profitable. It is housed, however, in an old building that is less than optimal for current skilled nursing care.

### Assessment

As with most areas of New York State, Schenectady has enough nursing home beds but insufficient non-institutional alternatives. The Commission calculates that approximately 32 current Schenectady nursing home residents can be cared for in an ALP. Availability of ALP beds will reduce current and future need for skilled nursing beds.

The owner of The Avenue and Dutch Manor nursing homes stated that the homes will submit a certificate of need application to the State for a single replacement facility of both facilities, with an amalgamated downsizing by 68 beds. In addition, the Dutch Manor would need to be renovated to be suitable for an ALP.

### ***Recommendation 3***

#### **Facility (ies)**

Glendale Home (Schenectady County)

#### **Recommended Action**

It is recommended that the Glendale Home downsize by approximately 192 RHCF beds to approximately 168 RHCF beds to be operated in the newest building.

#### **Facility Description(s)**

Glendale Home is a residential health care facility owned and operated by Schenectady County. It provides baseline services and some short-term care. The home decertified 168 beds in 2002 resulting in a certified capacity of 360 beds, staffing only 305. Approximately 87% of its certified beds were occupied in 2003.

Glendale Home faces many challenges. Its occupancy is low, which is driven by competition in its geographic area. The facility operates at a substantial operating loss, which the County is required to subsidize. The subsidy in 2005 was \$6.4 million, which accounted for 22% of the home's operating budget. The facility had a high case mix index in 2003 (1.10), and correspondingly relatively few of its residents are low-acuity. The home, however, has had quality issues, including 10 deficiencies and two immediate jeopardies in its last survey.

The facility now operates beds in two of its three buildings, one with 137 beds and built in 1934, and one with 168 beds, built in 1979. The remaining building, built in 1960, has no beds, and is instead used for administrative and support services. Much of this building stands vacant.

Assessment

The Glendale Home is having difficulty filling its beds with appropriate residents given its large size. Furthermore, a large number of Schenectady residents seek long-term care in neighboring Saratoga County, which has just received approval for two new facilities. Potential Glendale Home residents also seek care in Albany and Rensselaer counties.

This plan to downsize Glendale Home will use the resources available on its existing campus, which will minimize the dislocation of current residents and mitigate any potentially negative impact on long-term care services in Schenectady County.

## WESTERN REGION

### ACUTE CARE RECOMMENDATIONS

#### *Recommendation 1*

##### Facility (ies)

Millard Fillmore Hospital – Gates Circle (Erie County)

##### Recommended Action

It is recommended that Millard Fillmore Hospital – Gates Circle close in an orderly fashion. It is further recommended that Millard Fillmore Hospital – Gates Circle's 75 RHCF beds be preserved and transferred to DeGraff Memorial Hospital.

##### Facility Description(s)

Millard Fillmore Hospital - Gates Circle is a 189-bed, acute care hospital, and is a member of the Kaleida Health Care System. It provides emergency, medical/surgical and outpatient care. Gates Circle has specialized programs in neurology and stroke care, and is a designated stroke center in the Western Region. Gates Circle had approximately 7,800 discharges and 18,000 emergency department visits in 2004. Medicaid-covered and uninsured patients represented 10% of total discharges. Approximately 26% of inpatients live in medically underserved areas. Gates Circle also houses 75 skilled nursing facility beds, which offers subacute short-term rehabilitation care.

### Assessment

Erie County, in which Millard Fillmore Hospital – Gates Circle is located, has substantial excess inpatient capacity. The greater Buffalo metropolitan area and Erie County's population continues to shrink. Erie County's population is projected to further decline by 15% between 2000 and 2030. Erie County's inpatient capacity, however, has not correspondingly dropped. As a result, there are numerous underutilized facilities in the Buffalo area. To preserve competitive market balance, it is essential that both of the region's two major hospital systems – Kaleida Health and Catholic Health System – participate in downsizing their facility infrastructure.

Within the Kaleida System, Millard Fillmore Hospital – Gates Circle has been identified as the optimal candidate for closure. Among the Kaleida System hospitals, the Gates Circle campus is outdated and in need of extensive capital upgrades. It is underutilized, and had an occupancy rate of 59% of certified beds in 2004. Analysis measuring Gates Circle's capacity to close indicated that all of its patients could be readily absorbed by its coverage partners, which include Buffalo General (also a Kaleida member), Erie County Medical Center, Sisters of Charity Buffalo, and Kenmore Mercy hospitals.

The hospital's long term debt is part of Kaleida Health's \$191 million indebtedness, including \$155 million that is DASNY and HUD insured. Following consecutive losses in its first five years as a system, Kaleida Health had a positive and growing bottom line for the past three years. In 2005, Kaleida Health posted a \$26 million profit on \$935 million in revenues. Of those amounts, Millard Fillmore-Gates Circle contributed a \$14 million surplus on revenues of \$170 million. The remaining \$12 million surplus was spread across the systems' other four hospitals and its nursing facilities.

## ***Recommendation 2***

### **Facility (ies)**

St. Joseph Hospital of Cheektowaga, New York (Erie County)

### **Recommended Action**

It is recommended that St. Joseph Hospital of Cheektowaga close in an orderly fashion.

### **Facility Description**

St. Joseph Hospital of Cheektowaga, New York is a 208-bed acute care hospital, and a member of the Catholic Health System – Buffalo Hospital System. It provides emergency, medical/surgical, and outpatient care. The hospital had approximately 5,842 discharges and 22,477 emergency department visits in 2004. Medicaid-covered and uninsured cases represented just 5% of discharges, and 4% of patients came from medically underserved areas in 2004. St. Joseph's had a 3.4% operating margin in 2003. The hospital has \$3.3 million of (non-DASNY) long-term debt. St. Joseph employed approximately 555 full time equivalent employees in 2003.

### **Assessment**

As noted above, Erie County is substantially over-bedded and presents major opportunities for each of the major systems to downsize and reconfigure acute care services. Within the Catholic Health System, the underutilized St. Joseph Hospital has been identified as the optimal candidate for closure. St Joseph Hospital and Sisters of Charity Hospital, another member of the Catholic Health System, are less than 6 miles apart. Both of these hospitals have occupancy rates of less than 50% based on licensed beds. St. Joseph filled approximately 44% of its licensed beds and 58% of its available beds in 2004. Analysis performed by the Commission indicates that St. Joseph's patients could readily be absorbed by the hospital's coverage partners, which include Mercy Hospital and Sisters of Charity Hospital, which are both members of the Catholic Health

System, and by Millard Fillmore Suburban Hospital, Buffalo General Hospital, and the Erie County Medical Center. St. Joseph does not provide unique services and is not a major provider of care to vulnerable populations.

The Catholic Health System has developed creative and productive alternate uses for decommissioned hospitals and there may be potential to redevelop the St. Joseph site. Catholic Health System, for example, has worked with the New York State Department of Health to develop its Mercy Ambulatory Care Center (MACC) program in Orchard Park. The MACC has an emergency room and two inpatient beds for patients who require up to 36-hour length of stay. The campus also includes physician offices, a laboratory, x-ray machines, a pharmacy, and a diagnostic testing facility. Not all providers on the campus are part of the CHS; in fact, many are simply tenants in the facility's "medical mall."

### ***Recommendation 3***

#### **Facility (ies)**

DeGraff Memorial Hospital (Niagara County)

#### **Recommended Action**

It is recommended DeGraff Memorial Hospital downsize all 70 medical/surgical beds and cease operation as an acute care hospital. It is further recommended that DeGraff Memorial Hospital convert completely to a Residential Health Care Facility encompassing its existing 80 RHCF beds and the 75 RHCF beds to be transferred from Millard Fillmore Hospital- Gates Circle.

#### **Facility Description(s)**

DeGraff Memorial is a 70-bed acute care hospital, and a member of the Kaleida Health Care System. It provides emergency and medical/surgical care. It also houses an 80-bed skilled

nursing facility unit. DeGraff provided nearly 3,000 discharges and approximately 7,500 emergency department visits in 2004. 7% of its inpatients were Medicaid-covered or uninsured in 2004, and 2% of patients came from medically underserved areas.

### **Assessment**

Using the Commission's framework criteria, DeGraff Memorial performed poorly on quality, viability, and availability of services. Analysis performed by the Commission indicated that its average daily census of 46 acute patients could be readily absorbed by the hospital's coverage partners, which include Kenmore Mercy, Millard Fillmore Suburban, Buffalo General, Saint Mary's, Erie County Medical Center, Sisters of Charity, Millard Fillmore and Women and Children's hospitals. The hospital's long term debt is reported with that of the Kaleida system.

There is an excess of medical/surgical beds in the Western region, and patients' access to care will not be compromised if DeGraff closes. Given the ready access to more comprehensive services at neighboring hospitals, there is no need for the medical/surgical component of DeGraff. However, as described in the long term care report, DeGraff operates a well-utilized skilled nursing facility that should be maintained. The occupancy of its SNF is 97%. DeGraff's physical plant is in good condition. The conversion of DeGraff to a long-term care facility will mitigate the effects of its closure as an acute care facility, and will enable the provision of needed long-term care services in the Buffalo metropolitan area.

### ***Recommendation 4***

#### **Facility (ies)**

Sheehan Memorial Hospital (Erie County)

**Recommended Action**

It is recommended that Sheehan Memorial Hospital be maintained as an Article 28 provider. It is further recommended that 69 medical/surgical beds at Sheehan Memorial hospital be downsized. It is further recommended that 22 inpatient detoxification beds currently at Erie County Medical Center be transferred to Sheehan Memorial Hospital, provided that the Commissioner of Alcoholism and Substance Abuse Services approves such transfers. It is further recommended that Sheehan Memorial Hospital enhance its community based ambulatory care services, be licensed to provide methadone maintenance, and be licensed as an Article 31 provider of outpatient psychiatric services, provided that the Commissioner of Alcoholism and Substance Abuse Services and Commissioner of Mental Health approve such actions.

**Facility Description(s)**

Sheehan Memorial Hospital is a safety net provider, and is located in a poor, underserved community in downtown Buffalo. Although it is licensed for 109 total beds, 69 medical/surgical beds were taken out of service in 2003. It currently operates 30 substance abuse rehabilitation beds and 10 medically managed detoxification beds. As part of its restructuring plan, Sheehan also closed its emergency room.

Sheehan operates at 90% occupancy of its staffed beds. It offers adult and pediatric primary care, diagnostic services, radiology, and has specialty clinics in gynecology, cardiology, orthopedics, pulmonary care, urology, general surgery, and podiatry. Sheehan had approximately 1,100 discharges in 2004. Its current ambulatory care volume is approximately 11,500 visits. With approximately 240 full-time equivalent employees, Sheehan is an important employer in its community and its large campus serves as a neighborhood anchor.

Sheehan is successfully executing a turnaround plan. Sheehan first entered chapter 11 bankruptcy protection in 2002. Following continuing financial and leadership problems, Sheehan reconstituted the Board under new leadership, and again sought chapter 11 bankruptcy protection in 2004. Sheehan has since engaged a new chief executive officer, entered into collaborative

relationships with Grace Manor Nursing Home and Kaleida Health, and cut costs by half. After suffering from yearly deficits, Sheehan posted a nearly \$4 million surplus in 2005. Sheehan expects to emerge from bankruptcy in 2006 with a remaining \$4 million debt service. It has virtually no pension obligations.

Built in 1976, Sheehan is among the newer hospitals in Erie County. The physical plant is in relatively good condition. One of its five floors that had housed medical/surgical beds is currently vacant.

### Assessment

Sheehan has voluntarily downsized and reconfigured its services to align with the greatest needs of its community: substance abuse treatment and outpatient services. The closure of its emergency room and medical/surgical beds reduced duplicative services that are now provided by more comprehensive nearby facilities. The refocused Sheehan fills a critical need. In Erie County, Sheehan provides 38% of drug detoxification and rehabilitation services and 44% of hospital inpatient substance abuse services. Residents of Sheehan's service area are 2.3 times more likely to be admitted to substance abuse treatment programs than the County's residents as a whole.

It is feasible to close Sheehan. Sheehan has low utilization and is financially vulnerable. Its inpatients could be absorbed by its principal coverage partner, Erie County Medical Center. Sheehan is small and is not formally linked to a larger partner or system.

However, there are compelling reasons why Sheehan should remain open and be strengthened. Sheehan offers accessible, culturally competent primary and specialty care to a poor, underserved community whose members have higher rates of morbidity than Erie County residents as a whole. Seventy-nine percent of Sheehan's patients are minorities. One third of Sheehan's service area residents live in poverty, compared to 12% for Erie County as a whole. Forty percent of Sheehan's patients do not use a car as their primary means of transportation; many walk to Sheehan for care. Sixty-eight percent of Sheehan's detoxification/rehabilitation

patients have at least one physical co-morbidity, including cardiovascular disease, asthma, diabetes, hypertension, cancer or HIV.

Of the two inpatient substance abuse providers in Erie County, Sheehan and Erie County Medical Center(ECMC), only Sheehan is operating at capacity. At ECMC, substance abuse services are a minor component of the hospital's overall mission. The transfer of Erie County Medical Center's 22 detoxification beds to Sheehan would give patients the benefit of a comprehensive, focused, high quality program in a facility where substance abuse treatment is the major service line.

Sheehan is a vital provider of services to a community with severe health care needs. Following years of mismanagement, the current board and executive leadership is capable and committed. With a consolidation of substance abuse services and expansion of outpatient care, Sheehan provides access to health care for disadvantaged patients and is a public health asset worth preserving.

### ***Recommendation 5***

#### **Facility (ies)**

Erie County Medical Center/Erie County Medical Center Corporation (Erie County)  
Buffalo General Hospital/Kaleida Health (Erie County)

#### **Recommended Action**

It is recommended that the facilities controlled by the Erie County Medical Center Corporation and Kaleida Health be joined under a single unified governance structure under the control of an entity other than Erie County Medical Center Corporation, Kaleida Health, or any other public benefit corporation. It is further recommended that this entity consist of a reconstituted single

board including representation of Kaleida Health, the Erie County Medical Center Corporation, the University at Buffalo School of Medicine and Biomedical Sciences, and community leaders. If the Commissioner of Health determines that the single board proposed by the member entities does not meet these requirements, it is further recommended that the Commissioner of Health alter the composition of the board to satisfy these requirements. It is further recommended that this entity have unified management with powers sufficient to compel the service mix provided at any of the individual institutions under its control. It is further recommended that the joined entity utilize existing infrastructure to the extent possible to consolidate all necessary services into clinical centers of excellence, including tertiary, quaternary, psychiatric, and long term care services. It is further recommended that the joined entity develop new infrastructure in which to locate comprehensive heart and vascular services. It is further recommended that the Commissioner of Health:

- (i) Refrain from either approving any applications that have been or will be filed by either entity or providing any other consent requested by either facility, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure pursuant to the terms of this recommendation, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff;
- (ii) If Kaleida Health and Erie County Medical Center Corporation fail to execute such an agreement by December 31, 2007, close either Buffalo General Hospital or Erie County Medical Center and expand the other to accommodate the patient volume of the closed facility; and
- (iii) Present to the State Legislature any necessary draft legislation in a time and manner sufficient to implement this recommendation by June 30, 2008.

#### **Facility Description(s)**

Erie County Medical Center (ECMC) is a 550-bed hospital sponsored by a public benefit corporation established in 2004. The hospital is situated on 67-acre, largely undeveloped campus. ECMC provides comprehensive acute care services, including level I trauma, burn care, kidney transplant, psychiatry, physical medicine/rehabilitation, and detoxification services.

ECMC has one of the highest case mix indexes of all New York State hospitals. According to ECMC leadership, ECMC had approximately 12,000 discharges and 48,000 emergency department visits in 2005. Its numerous outpatient clinics had approximately 243,185 visits in 2004. ECMC serves a large number of indigent patients; approximately 25% of its inpatients were Medicaid-covered or uninsured in 2004, and 25% of its patients live in medically underserved areas. ECMC reports that approximately 70% of its 505 available beds are occupied. ECMC's main campus has 125 skilled nursing facility beds. In addition, ECMC operates the Erie County Home, a 586-bed skilled nursing facility. Virtually all of the nursing home beds operated by ECMC are occupied. ECMC has \$106 million in long-term debt, most of which is secured by the County. ECMC has approximately 2,787 full-time-equivalent employees.

Recently resolved litigation required that the County subsidize ECMC through 2008. The amount of this subsidy decreases each year: \$28 million in 2004, \$19 million in 2005, \$20 million in 2006, \$14 million in 2007. After 2008, the County will provide ECMC with \$8 million annually as debt service coverage. ECMC finished in the black including the subsidy in 2005. It is projecting a surplus in 2006 of approximately \$16 million.

Buffalo General Hospital (BGH) is a 501-bed member of the Kaleida Health Care System. BGH is located on the Buffalo Niagara Medical Campus, a densely developed site that also houses the Roswell Park Cancer Institute and other research institutions. BGH is the focal point for Kaleida's development of high-tech, tertiary care services. It provides comprehensive medical/surgical, psychiatry and physical medicine/rehabilitation services. It had approximately 17,000 discharges and 38,000 emergency department visits in 2004. Nineteen percent of BGH's inpatients were Medicaid-covered or uninsured in 2003, 23% of its patients live in medically underserved areas. The hospital reports an occupancy rate of 67% of its 501 available beds. BGH's long-term debt is reported together with other components of the Kaleida System. BGH has approximately 2,300 full-time-equivalent employees. Since its founding seven years ago, the Kaleida system has voluntarily decertified 638 beds and eliminated more than 1 million square feet of space.